after the second hemorrhage was the patient's condition such as to justify the carrying out of this procedure. The autopsy showed us that excision of the ulcer could never have been done without removal of both the lower end of stomach and upper end of duodenum; even if gastro-enterostomy had been performed, the fatal erosion of the large vessel involved would in all probability have occurred just the same. It is difficult to see, therefore, in the retrospect of the case, knowing what we finally learned of the lesion present, how the ultimate catastrophe could have been averted.

## CALIFORNIA ACADEMY OF MEDICINE.

### REGULAR MEETING FOR OCTOBER.

DR. WILLIAM FITCH CHENEY read a paper entitled "Report of a Fatal Case of Gastric Ulcer, with Post Mortem Findings." Before reading his paper, Dr. Cheney called attention to the fact that the title as printed on the notices was somewhat erroneous; it was really a case of gastro-duodenal ulcer. The paper in full will be found on another page of the Journal.

Dr. Quinan said that there were several points of interest to him in the paper of Dr. Cheney. The temperature range was of great interest. Prominent surgical authorities were about equally divided as to whether early operation was advisable or not. In the present case, from the blood studies reported, he had no doubt that the method of internal medication as followed by Dr. Cheney was the best treatment that could have been employed. He asked whether the use of eggs in the enemata which were given to the patient was for a desired emollient effect, or for nourishment.

Dr. Barbat recalled a patient that he had recently seen in whose case there were some points of similarity to that of Dr. Cheney's patient. When he first saw her she seemed anemic and weak; the blood count showed 2,500,000, and the hemoglobine was 65 per cent. Pain after eating was marked and the diagnosis of gastric ulcer seemed very clear. Tonic and simple diet were prescribed. She improved rapidly and was not again seen until two months ago, when all the symptoms of gastric ulcer were again well marked and her general condition was worse than when first seen. Between Saturday and Monday evening she had four quite severe hemorrhages, and it was decided to operate. Cocain anesthesia was employed and the abdomen opened. Careful examination of the stomach did not reveal the presence of an ulcer, though every clinical symptom pointed to its presence. The viscera seemed to be absolutely bloodless. Patient died shortly after, and even when the stomach was removed the ulcer was with some difficulty found on the lesser curvature. It was small, indurated, and at the center was a perforation into a blood-vessel. He thought that a great deal of damage was caused by the destruction of blood, and that the depression, anemia, etc., was as much due to this destruction of the blood as to the ulcer itself or to the loss of blood by hemorrhage. The specimen was presented and examined with great interest by those present.

Dr. Wilbur mentioned a rather unusual case that he had recently encountered. The patient was a young man who had, shortly before coming under observation, been in the Philippines. The only history obtainable was that after a hearty meal the young man had engaged in a scuffle and that shortly afterward some pain in the abdomen was noted. It was not at the region of the stomach, but was near McBurney's point. There was no special indication of appendicitis, however. He had a severe attack of pain, while at Stanford University, to relieve which, chloroform was employed. On coming out from the anesthetic there was great relief. Later the pain returned; dullness and tenderness were found in the right hypochondriac region, and it was decided to send him to this city for hospital attention. He arrived in a comatose condition. There was no vomiting save after medicines had been taken. The temperature ran up rapidly on the following day, appendicitis was suspected and operation was decided upon. The appendix was found to be only a trifle hyperemic. When the belly was opened a few drops of a milk-like fluid ran out. He vomited one and one-half quarts of mixed food and blood. The wound was closed and an opening made higher up, which disclosed the presence of an ulcer; this was cut out and the wound sutured; the patient died a few hours later of surgical shock.

Dr. Ophuls, in discussing the case presented by Dr. Cheney, said that two points of interest presented themselves to him. First, the ulcer was found with some difficulty, even after the removal of the stomach post mortem. He doubted that it could have been found at all if an operation had been performed; certainly not easily. Second, the history pointed to two ulcers—one old and healed and the other more recent. It is certainly true that very large ulcers of the stomach wall may exist without producing symptoms at all diagnostic. He agreed with Dr. Barbat in the belief that as much damage to the patient resulted from the simple destruction of blood as from the ulcer itself or the hemorrhages.

Dr. Huntington dwelt upon the fact that dilatation of the stomach, which is supposed to be an ever present symptom when the pylorus is affected, was absent in the case reported by Dr. Cheney, and was absent in a number of cases observed by himself; or, if not absent, too trifling to be of note. He referred to a patient whose

history has been published. The patient was operated upon for what was supposed to be cancer of the stomach. Gastroenterostomy was performed and the man entirely recovered and is still alive and well. He thought that ulcers of this tract were undoubtedly due to some blood change, yet the fact remained that very many large ulcers healed without serious injury to the individual. He mentioned a case in which the patient had had a very large hemorrhage, yet eventually recovered. It is impossible to say when the blood plays an important part and when not. He was of the opinion that operations were not performed so early as should be the case, and that he who can early determine when internal treatment should be employed and when operative measures alone will suffice, is an exceedingly careful and expert observer.

Dr. Rixford said that he shared the responsibility with Dr. Cheney, for he had early been called in consultation. After the first hemorrhage it was positively decided to operate as soon as possible; he dared not at the time on account of the low condition of the patient. When the proper time had arrived, the man had another hemorrhage, and this postponed any chance of operation for the time. In these cases the question of operation is a very serious one, for the patients are seldom in good condition and the operation itself is by no means an easy one. In the present case, he thought that if a gastroenterostomy could have been performed the patient would probably have recovered. He then reviewed the histories of four or five cases of ulcer of the stomach in which operative measures had been undertaken, and in some with good results. In one there was a large indurated area near the pylorus which he thought cancerous; gastroenterostomy with the Murphy button was performed and the patient recovered. In his opinion the proper operation in most, if not all of these cases, is gastroenterostomy.

Dr. Brown called attention to the great importance of the proper medical treatment of these cases. He thought it unwarranted to give the patient anything by the mouth for at least two weeks after a hemorrhage from stomach ulcer. The danger, he thought, was in feeding these patients too much, or allowing too much material to enter the stomach. He stated that it was quite possible to sustain a patient for from four to six weeks simply by rectal feeding. He advocated the employment of remedial agents that would promote coagulation, and suggested gelatine hypodermically, and calcium chloride mixed with the enemata.

Dr. Taylor was asked by the chair to give his opinion as to the possibility of feeding, or sustaining the patient, by concentrated poteins and carbohydrates, introduced hypodermically. He said that the proceeding had been demonstrated upon animals, but that it had not, so far as he knew, been employed in the actual treatment of patients. There was nothing to prevent its use, however.

Dr. Cheney, in closing the discussion, replied to Dr. Quinan's question as to the use of eggs by stating that it was by no means original with him. He had found, however, that the yolks of eggs were mixed with the milk and the whole then peptomized, the enema was better retained than when the milk alone was used. In reply to Dr. Barbat, he could not recommend an operation as soon as the diagnosis was made, for the reason that a great many of these patients recover without surgical interference. It has further been stated, on excellent authority, that from four to five per cent of those who die from all causes, and on whom post mortem examinations have been made, show they have gastric ulcers that have healed. He thought that instead of there having been two ulcers, there had been but one; that it had healed more or less well, and then broken down again. In regard to the question of dilatation, he stated that the succussion splash had been noted in the present case, but that no dilatation was found. He thought the succussion splash a questionable diagnostic feature. He thought that forty-eight hours was a sufficient time to elapse after hemorrhage before introducing anything into the stomach. While Dr. Brown was theoretically correct in assuming that a patient could be well sustained for several weeks by rectal feeding alone, still in cases of ulcer of the stomach, with hemorrhage, it was not possible to more than keep the patient in the lowered conditions by this means; the loss of blood must be made up, and this could not be secured by rectal feeding alone. He strongly approved of the use of gelatine, to secure coagulation, when it could be applied locally, as in hemorrhage in cirrhosis of the liver. He could not approve of its use hypodermically, however, because of the generally coagulative action.

Drs. Newmark and Sherman presented a patient of whom Dr. Newmark gave the following history: He came to San Francisco in June, 1901, complaining that for four years he had been subject to very severe headaches; for the previous two years he had been so troubled to only a slight degree, but that a return had recently been noticed. There was also a partial hemianopsia. There was a family history of similar severe headaches. The headaches grew worse and the boy was given morphine hypodermically, almost constantly, to relieve the pain. Later he was again brought to the city, and when once more presented to Dr. Newmark he was comparatively free from pain and looked well. Examination showed choked disks and slight facial paresis. A tumor of the brain seemed the clear diagnosis, but its location could not be readily determined. After several examinations a tender spot was located on the right side of the head which seemed constant and always tender to pressure. This spot conformed fairly well to the

location of the lower facial center. He was then so fairly well and comfortable that operation was indicated and urged only on account of the choked disks. He was operated upon in August, 1901, and almost immediately afterward his vision grew rapidly worse. There was much pressure from within and some brain matter protruded. A sarcoma of the small-celled variety was diagnosed. In April it became necessary to once more operate. The two operations have been followed by paresis of the left hand and anesthesia of the left upper extremity; the vision is slightly better..

Dr. Cheney asked how long the cerebral hernia, or bulging, had existed, and Dr. Newmark replied that it had been present since the first operation.

Dr. Sherman said that at the time of the first operation, when the bone flap was lifted, the brain bulged out through the opening, and that differentiation between tumor and brain tissues could not be made. Somewhere between 30 and 40 c. c. of brain matter had been removed during the operation. Healing was uneventful. At the second operation he had removed much more brain tissue than that which bulged through the opening. He used the curet and the operation was followed by temporary hemorrhage, so a drain was placed and allowed to remain for forty-eight hours, after which it was removed and the wound closed. The skin had almost united when hernia cerebri appeared. Straps were applied and the boy sent home. The bone flap is now lifted, like a hinged flap, but the pressure from within. Occasionally a few amber-colored drops of fluid escape and then there is relief from pain and headaches. At the time of the second operation, and subsequently, the brain has been carefully explored by means of the tenotome, but no sinus has been found. It is a serious question, at present, whether to lift the flap again and remove the bulging tissue ,or to leave it as it is.

Dr. Somers referred to a case of injury to the brain, resulting in meningocele, which he had seen some four or five years ago. A small boy was accidentally shot in the frontal region. Trephining was performed, a button removed and the bullet extracted. The button was cleansed and replaced. A few days later pulsation and increase in size were noted, and the button was forced out. A mass of brain and granulation tissue extruded which was tender on pressure; for this reason strapping could not be used. The patient was referred to Dr. Rixford and skin-grafting was decided upon. Grafts were taken from the thigh, they united readily and the tumor steadily decreased in size.

Dr. Sherman said that the present condition was not a true hernia cerebri; it was a carcinoma of the brain, which, by causing pressure, forced the brain through the wound.

Dr. Rixford called attention to the fact that in the case cited by Dr. Somers, the skin-grafting had certainly been of some benefit; contraction of the skin grafts had exerted the gradual pressure that reduced the mass, whereas the pressure by straps could not be tolerated. He further expressed the opinion that, as McBurney of Glasgow has demonstrated, it is often a good thing to allow the tumor of the brain to force a large amount of tissue out, and then scrape it off. Of course, such procedure is modified by the size and shape of the mass in each case.

Dr. Mark White, of the M. H. Service, exhibited some specimens and slides of the Distomum Fineuse.

He said that but little had been written about it, and but little was known. It is not native to this country, but is found more or less generally in the Orient. The habitat of the worm is the fresh water or pond snail. He had observed the presence of this infection in seventeen patients, sixteen of whom had died of the plague. There are no diagnostic features, and the presence of the infection can only be determined by finding the eggs of the worm in the feces. The worm is swallowed, digested, and portions of the worm and its eggs may be found in the feces. It acts more or less directly upon the walls of the bile passages, causing a thickening, and produces death in from six to eight years. There is said to be a barrel shaped alteration in the shape of the liver, but this is not always present, nor is it easy to determine, even if present. The infection produces chronic diorrhœa, edema and jaundice He had seen but one live worm, and had not been able to detect the presence of the disease before death in any case. In his opinion, if the pond snails of this country become infected by the worm, brought from the Orient inadvertently, the disease will soon be epidemic and very dangerous. All animals, including the human animal, coming from the Orient, and all materials in any wav liable to convey the worm into this country, should be very rigidly examined. He was of the opinion that it would be found here sooner or later, as would also most Asiatic diseases.

## DEATHS.

Dr. John Byrne, president of the faculty of St. Mary's Hospital, Brooklyn, and one of the greatest of American gynecologists, died in Montreaux, Switzerland, the first of this month. Dr. Byrne was born in Ireland in 1825 and came to Brooklyn in 1848. He was one of the founders of the Long Island College Hospital, and in 1868 organized St. Mary's Female Hospital in Dean street. He was the author of many articles on gynecology and surgery.

Dr. Gregory J. Phelan, a pioneer of 1849, died on the 5th inst. in San Francisco. He was born in New York 1822. He was connected with St. Mary's Hospital for many years. Dr. Phelan was stricken with paralysis about three years ago and never recovered.